DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11054 (Rev. 07/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / ENTERAL NUTRITION PRODUCT ATTACHMENT (PA/ENPA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA) Completion Instructions (HCF 11054A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient

3. Recipient Medicaid Identification Number

SECTION II — TYPE OF REQUEST

4. Indicate the start date requested or the date the prescription was filled (required).

5. Check one:

❑ This is an initial PA request for this drug, for this recipient, by this provider.
❑ This is a request to renew or extend previously approved PA for therapy using this drug.

First PA number_____

❑ This is a request to change or add a new National Drug Code (NDC) number to a current valid PA.

First PA number_____ NDC number to add _____

SECTION III — PRESCRIPTION INFORMATION

6. Product Name	7. Quantity Ordered
8. Date Order Issued	9. Directions for Use of Product
10. Daily Dose	11. Refills
12. Name — Prescriber	13. Drug Enforcement Administration Number

Continued

SECTION IV — CLINICAL INFORMATION

14. List the recipient's condition the prescribed drug is intended to treat. Include the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis for pharmaceutical care recipients. Include the expected length of need. If requesting a renewal or continuation of a previous PA approval, indicate any changes to the clinical condition, progress, or known results to date. Attach another sheet if additional room is needed.

15. Indicate source for clinical information (check one).

- ❑ This information was primarily obtained from the prescriber or prescription order.
- ❑ This information was primarily obtained from the recipient.
- ❑ This information was primarily obtained from some other source (specify). _____

_____

_____

16. Use (check one)

- ❑ Compendial standards, such as the United States Pharmacopeia - Dispensing Information (USP-DI) or drug package insert, lists the intended use identified above as an expected indication.
- ❑ Compendial standards, such as the USP-DI, lists the intended use identified above as a [bracketed] accepted application.
- ❑ Compendial standards, such as the USP-DI or drug package insert, lists the intended use identified above as an expected use.
- ❑ The intended use above is not listed in compendial standards. Peer-reviewed clinical literature is attached or referenced. (Reference — include publication name, date, and page number.)

17. Dose (check one)

- ❑ The daily dose and duration are within compendial standards of general prescribing or dosing limits for the indicated use.
- ❑ The daily dose and duration are **not** within compendial standards of general prescribing or dosing limits for the intended use. Attach or reference peer-reviewed literature which indicates this dose is appropriate, or document the medical necessity of this dosing difference. (Reference — include publication name, date, and page number.)

Continued

SECTION V — ADDITIONAL INFORMATION REQUIRED FOR ENTERAL NUTRITION SUPPLEMENTS

18. Indicate percentile (children only) and height.	19. Indicate percentile (children only) and weight.

20. Indicate the amount of weight loss, if any, and within what specific time span the weight was lost.

21. Check all that apply.

- ❑ This recipient is tube-fed.
- ❑ If not tube-fed, number of Kcal prescribed per day _____. Percent of total calories from this supplement _____%.
- ❑ This recipient can consume most normal table foods.
- ❑ This recipient can consume softened, mashed, or pureed food, or food prepared by blender.
- ❑ This recipient has a clinical condition, as indicated in Section IV, which prevents him or her from consuming normal table, and softened, mashed, or pureed food or food prepared by blender.
- ❑ Comprehensive documentation of this recipient's condition is presented previously in Section IV.
- ❑ This recipient is eligible for food stamps.
- ❑ This product or a similar product can be obtained from the Women, Infants, and Children program.

22. **SIGNATURE** — Pharmacist	23. Date Signed

24. Please notify me of approval / denial by:

- ❑ Fax (include Fax number) _____
- ❑ Telephone (include telephone number) _____
- ❑ No special notice needed.

Reset Form